educational value of such an event is particularly interesting and future studies of larger medical student groups are warranted.

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TACKLING CULTURAL AND SOCIAL CHANGE: AN EXAMPLE OF A SUCCESSFUL QUALITY IMPROVEMENT INITIATIVE TO ENHANCE PATIENT SAFETY
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Purpose: This presentation will describe a quality improvement initiative that occurred in radiation therapy departments across British Columbia. This initiative harnessed the investigational response to several safety events in the province. The reformative change involved the implementation of a Provincial Patient Identification Policy specific to radiation therapy delivery, across multiple centres with different operational needs.
Methods and Materials: The operationalization of the Provincial Patient Identification Policy utilized quality improvement fundamentals from the Plan-Do-Study-Act model. This initiative involved not only a simple procedural change, but also challenged deeply held beliefs and assumptions of Radiation Therapists in British Columbia. Radiation Therapists believed strongly that involving patients in daily identification protocols would create barriers to developing rapport and trust. As such, education involving the patient identification policy had to tackle the social aspects of change implementation, as well as the increasing effort to focus on improving patient experience by health care providers. Early on, this was recognized by Clinical Educators, and actively addressed. Transformative education took place which challenged the learners to examine their beliefs about patient perspectives and how this related to patient safety. Efforts to educate about the change were well coordinated with the implementation of the change itself. After the initial change, formal avenues for feedback were provided, and the procedures were refined. After several months, a provincial audit was performed.
Results: Preliminary audits performed on patient identification at two radiation therapy centres indicate that the implementation of the Provincial Patient Identification Policy has been a success. Two types of audits were carried out, these will be described.
Conclusions: Identifying and addressing the social aspects of change implementation is key to ensuring the success of quality improvement initiatives. Despite common myths and anecdotal evidence from Radiation Therapists, patients have appreciated their active involvement in daily treatment and safety checks.

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THE HURDLES TO ONE HUNDRED: BARRIERS TO PEER REVIEW IN RADIATION ONCOLOGY
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Purpose: Peer review is the evaluation of the creative work or performance by other people in the same field to enhance the quality of work, or performance. In an effort to improve quality and standardization, a number of initiatives have been put in place at the national and provincial levels. In 2011 and updated in 2013, the Canadian Partnership for Quality Radiotherapy (CPQR) published Quality Assurance Guidelines for Canadian Radiation Treatment Programs. This document recommends that all radiation treatment plans administered with adjuvant or curative intent, and others plans where there is a significant potential for adverse patient outcome, undergo Radiation Oncologist peer review. The aim of this project was to identify and mitigate the barriers to an effective peer review program, to achieve the recommendations set forth in the CPQR guidance document.
Methods and Materials: A large urban comprehensive cancer centre performed peer review employing a site group model. 10 site groups are represented meeting on a weekly basis. A three month retrospective analysis was performed identifying all cases treated within the time period. Each case was characterized by: site; month; referral to review; and review status. Cases not referred for review and or did not undergo peer review were examined for barriers to successful peer review.
Results: The average peer review rate for the three month time period was 85.43%. 16.61% of patients did not receive a referral to peer review. 3.38% of patients were referred for review, however did not undergo peer review. Identified barriers to successful peer review included; human error, workload, resource limitations and culture change.
Conclusions: Peer review; has the potential to identify errors; serves as a forum for continuing education; and catalyzes standardization. By mitigating the barriers to peer review including; human error; workload; resource limitations; and adopting a culture promoting the initiative an increasing number of cases can be successfully reviewed, resulting in a high fidelity system to increase patient safety.

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RADIATION INCIDENT SAFETY COMMITTEE AND THE NATIONAL SYSTEM FOR INCIDENT REPORTING IN RADIATION THERAPY: PARTNERS IN IMPROVING PATIENT SAFETY
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Purpose: The National System for Incident Reporting in Radiation Therapy (NSIR-RT) is an initiative between the Canadian Partnership for Quality Radiotherapy (CPQR) in partnership with the Canadian Institute of Health Information (CIHI). Cancer Care Ontario (CCO) has an established a Radiation Incident Safety Committee (RISC) with the goal of reducing the impact of radiation incidents across the province's 14 radiation treatment programs (RTP)s. CCO RISC has assessed its collective incident reporting processes in comparison to the provincial adoption of the NSIR-RT.
Methods and Materials: Facilitated by a face-to-face meeting of Primary Radiation Incident Leads (RILs), an assessment of current incident reporting processes of each regional radiation program was performed. Reporting tools, taxonomies and processes were collected for each of the 14 RPTs. The RILs met to discuss the current state of reporting in comparison to the CPQR proposed NSIR-RT. Benefits and barriers to the provincial adoption of the NSIR-RT platform were identified.
Results: 100% of RTPs had an established incident reporting process. 85% of RTPs reported radiation therapy incidents using software databases. Nine software systems were identified (three of which were developed in house) for the facilitation of incident learning. In addition, 100% of RTPs had locally specific incident reporting taxonomies. Evaluating the proposed NSIR-RT the following benefits and barriers were identified.

Benefits:
- Access to provincial dataset
- Unified taxonomy
- Cost neutral
- Reduced provincial reporting requirements

Barriers:
- Corporate buy-in
- Multiple data entry requirements/resources
- Access to provincial data-set
- Measures of success

Conclusions: Currently, 35% of RTPs are using NSIR-RT and 35% are in the progress of completing service agreements. In addition, work with CIHI to develop a CCO administrator role to